STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

TRANSCRIPT OF PROCEEDINGS

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ATTENDEES:

STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE:

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PUBLIC SPEAKERS:

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LARRY FRIEDMAN, M.D.

DON McCANNE, M.D.

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SAN DIEGO, CALIFORNIA, FRIDAY, MAY 30, 1997

5:30 P.M.

DR. ENTHOVEN: Pursuant to AB 2343, the task force has been charged with reviewing and reporting on the following aspects of managed health care in California:

The picture of health care service plans as it stands in California today, including, but not limited to, the different types of plans, how they work, how they operate, how they're regulated, the trends and changes in health care delivery and how these changes have affected the health care economy, academic medical centers and health professions education; whether the goals of managed care provided by health care service plans are being satisfied; a comparison of the effects of provider financial incentives on the delivery of health care and health care service plans, other managed care plans and fee-for-service settings; the effect of managed care on the patient-physician relationship, if any; the effect of other managed care plans on academic medical centers and health professions.

And in addition, the task force will formulate and present recommendations on regulation of managed care. These findings and recommendations will be published in a report due by January 1, 1998.

The task force has come here this

afternoon or evening in order to listen to comments and discussions from the general public. We are going around to various cities around California in order to gather firsthand information from people in each of the major communities. A couple of weeks ago we were in El Segundo, and in another couple of weeks or so we'll be in Fresno, et cetera.

And we're going to ask each of you who wish to speak and to address the task force to fill out a speaker card.

Are the cards available now?

DR. ROMERO: Back where that line is.

DR. ENTHOVEN: In the back? Would you then offer to people in the audience to help pass them out?

And then I would appreciate it if the cards would then be brought up to me. For one thing, that gives us a clear record and statement of the names of the people who -- and helps me introduce them to the rest of the audience.

Another is I'd like to have some idea as to how many people want to speak. Because that will relate to the question of how much time we can take with each person. We're scheduled to meet from now until 7:30. I'm afraid we will need to adjourn quite promptly at 7:30 because some people have planes to catch.

While you are addressing the task

force, we would like you to know that we must have in mind a number of questions that we will be seeking to answer based on the accumulation of what we hear, including do you have specific suggestions for improving managed care other than just abolishing it altogether or whatever.

We'd like to know your thoughts about what kind of system changes might be made that would make it better. We'd like to understand are your comments and concerns related to health insurance in general or specifically to HMO's or to preferred provider insurance or what have you.

We'd like to know can you tell us about your data sources. I mean, if you have particular concerns, can you share with us what data we might seek that would help us to evaluate this better. Can you identify the root causes of your concerns or comments.

You don't have to be able to answer these yourself, but we want you to understand we will be having those questions on our minds. And in some cases, task force members will be given the opportunity to ask you to draw out further your thoughts.

Copies of these questions are available in the framework for the hearings that are on the table in the back near the entrance to the room.

If you could make a few changes in

managed care, what would they be to help make managed care better for you and for your fellow Californians?

So let's see. This is how many we have so far? So we have about six or seven. I think what we'll do is to begin by asking you to limit your remarks to about five minutes and then more brief, if possible. And then task force members will engage you in conversation, and we'll take it from there.

We seem to have about six or seven. If anybody is planning to speak that hasn't filled one of these out, please do so because we do want to be able to manage our time. That is, you can submit these subsequently, but it will be helpful in managing this.

So please bring them up to the gentleman over there on your right, my left, if you have more.

Okay. We're going to start with Dr. Rodrico -- I'm sorry. I'm having problems with this. Is it psychiatric? Yeah, American Psychiatric Association, who wants to speak about the relationship between patients and physicians.

Munos. I'm sorry. I see now that I know it's Munos. Dr. Munos?

DR. MUNOS: Thank you, Mr. Chairman.

I am Rodrico Munos. I am the vice-president of the Mental Health Advisory Board here in San Diego. I am also a counselor of the San

Diego Medical Society. I am the president of the San Diego branch of the California Hispanic Medical Association. And I am the president-elect of the American Psychiatric Association.

Managed care practice is devastating in the care of psychiatric patients in San Diego. It has also been typical for many places in the State of California and in the places of the United States where I have been traveling.

As vice-president of the American Psychiatric Association and more recently as president-elect, I have been in touch with many professionals and many patients who have told me about the devastation created by managed care. The 15 largest mental health care groups now control up to 80 percent of managed care contracts around the country, have isolated psychiatric patients from other health care resources, they try to withhold diagnosis and treatment, and more recently have started to argue that there are too many physicians and much fewer are needed.

If we follow their thinking, we will need only one competent psychiatrist in San Diego. If that were the case, we would reduce our numbers to such a small group we would have enough psychiatrists to provide services at the county hospital, at the university centers, and at the navy hospital. We would be leaving 270,000 San Diegians without care.

So egregious is their practices that we the psychiatrists of America have decided to sue them, and we are doing so in Superior Court in New York. I would like to be in there participating in their discovery process that will produce a great deal of evidence in order to document abuse and mismanagement.

One of the most insidious practices of the HMO's - and this is typical for San Diego - is to award contracts to a large number of groups of primary physicians, who in turn contract with selected psychiatrists. This compartmentalizes care to such a degree that patients do not know who their psychiatrist may be. This not only disrupts care but destroys patient confidentiality.

About one year ago a patient who had been taking Prozac for two years asked me for a refill. His insurance requested that I complete five pages of minute information about this gentleman's life before he could have treatment. I told him I would rather treat him for free, which will be more fincially beneficial to him and to me, and I will be able to respect his right to privacy.

There was a teacher who needed psychotherapy, but the insurance company said that only psychologists could provide the therapy. My patient went through five different appeals, and now I continue to see him, but I get a form to renew care

every second visit.

Another patient, a high executive at a local concern, was in the throes of a manic episode when her insurance company denied care on account that psychotherapy medications were too expensive for a managed patient. She now is better, but she no longer trusts that she will ever get proper care if she again has a medical problem, even though her family, the community, and the company badly need her services.

Long ago I decided that my ethical principles would require that I refuse to see patients under some of the conditions created by the HMO's. Since then my practice to a large degree has been focused on what we call managed care refugees, people who already gave up on their insurance provider but they are now coming to see us at a discount, paying out of their own funds. They are paying twice, to the employer to provide no care and to us to provide the best care we can provide under their reduced conditions.

This is a dismal state of affairs. I would strongly request that the state correct the situation in which patients are increasingly more isolated from their physicians by numerous fears of decisionmakers that create barriers often impregnable to our patients.

I've read about the application of

managed care techniques to the Medicaid population. If the HMO's were successful in damaging so many middle class patients who were paying for their own insurance, what can we expect will happen to the poor, who have less protection and fewer supporters?

I would hope that the patients, their families, the professionals and the public come to the realization that the current strategies for managed care have been a failure and alternatives should be studied and implemented. Thank you.

DR. ENTHOVEN: Thank you, Doctor.

All right. We want to express our appreciation for sticking to the five minutes. That's very kind of you.

Do you task force members have questions?

DR. SPURLOCK: Thank you, Dr. Munos, for coming tonight. I appreciate your comments.

I'm very interested in the physician supply and physician need that you talked about at the very beginning of your presentation. And you described a discrepancy between what the behavioral health care companies had determined the need and your organization's determination of the need for psychiatrists in the San Diego area.

How did the behavioral health organization make that determination, and how did you in your organization make that determination about

the need for physicians?

DR. MUNOS: There was a study down at the county foundation counting psychiatrist and counting subscribers. They came to the conclusion that they could provide psychiatric care with four psychiatrists per 100,000. Today in San Diego we may have about 200 psychiatrists who are in practice. Between this place and the border with Mexico, there may be six psychiatrists. There may be 360,000 people there.

I would ask you whether you believe that those people are getting adequate psychiatric care.

DR. ENTHOVEN: Brad?

DR. GILBERT: Dr. Munos, can you separate at all how much of the problem is due to the severely limited benefits that are often available in mental health through most HMO's and most employer health plans? Because mental health is probably one of the most limited areas of benefit versus other practices that also cause problems, like, you know, restrictive formulas that you talked about with Prozac or wanting a lower level of care in terms of psychologist versus a psychiatrist potentially? Can you separate those two?

DR. MUNOS: Yeah, it's possible. What happened with psychiatrists is that in the full line we are the last one. We are the last ones to get

whatever moneys come out of the big pool that is distributed by the HMO's and others.

Most of the contracts under managed care here in San Diego belong to Pacificare and to Health Net. They contract with groups of primary physicians. The primary physicians can't decide how much they are going to pay the psychiatrists. If somebody decides that it's 70 cents per member per month, that's the rate of the day. Then somebody else says, well, I would like to pocket more money so I am going to offer 50 cents per patient per month. And there is some cases where the money was just 21 cents per patient per month.

It's possible to create a line at which you say below this line it's impossible to provide care. We are there. And we have national figures to show you. We are treated in such a way that some people believe that because of the geographic conditions of San Diego County we have become the garbage dump of managed care.

MR. RODGERS: Dr. Munos, you said that you're generally against managed care. Is there any model that you have seen that you would find acceptable?

DR. MUNOS: I believe the current circumstances exist not only because so many entrepreneurs came to the medical field but also because there has been great advance in medical

information systems. I do believe that if we even -- in the field if we make it so that we can compete with the entrepreneurs, changes, for example, in the antitrust legislation, we would be prepared to compete as long as it's acceptable that the total pool of money will be available to those who are providing the care.

What I am trying to say is that what has made the situation so difficult is that in the one dollar health allotment you start with the insurance company and the HMO's taking off the top 25 to 30. So that leaves 70. Of the 70, 30 may go to the hospital. So now you are with 40. Of the 40, twelve may go to the primary care physician. Four may go for administration.

So you may have a few cents left to distribute among the specialists, not knowing that in our field quite often we are the primary physicians to all these chronic schizophrenic patients that nobody else wants to see. And at this tine, with this system, with the equation I am mentioning, there is no chance that they are going to have the treatment they deserve.

MR. RODGERS: So do you feel that the issue is the amount of money in the pools that's the problem?

DR. MUNOS: That's the problem. The other one, of course, is the exposure that -- the

greediness of anybody who may be prepared to get a Knox-Keene license and come into the field and decide that he has a system that will provide the employers with savings at the cost of the employees. I would submit that if we do not pay the employers a huge tax exemption, then they will lose interest in the field, and we might be able to negotiate with the people who really count, who are the patients and their families.

DR. ENTHOVEN: Thank you very much, Doctor. I appreciate your coming.

DR. MUNOS: Thank you.

DR. ENTHOVEN: Our next speaker is going to be Dr. Larry Friedman, a physician from the University of California at San Diego, who will be talking about academic medical centers and education.

Welcome, Doctor.

DR. FRIEDMAN: Thank you very much. I'm the chief of the Division of Primary Care Pediatrics and Adolescent Medicine at the University of California, San Diego; also the interim medical director of primary care for the UCSD Medical Group; and also the president of the San Diego Society of Adolescent Medicine.

I have several comments about managed care as it pertains to academic medical centers, especially in San Diego and especially to the population that I provide direct services to.

On one hand, I think that managed care in many ways has been beneficial in that it has certainly forced academic medical centers and other health care providers to take a close look at health costs and health containment and has also placed a very large burden on outcomes and outcome studies. Therein, I think, lies both one of the problems and one of the great opportunities.

The weight on outcome studies needs to be funded. And one of my major concerns is that managed care companies are not funding those outcome studies upon which they're basing a lot of their parameters and requirements.

I'd perhaps ask this committee to go no further than to look at the front page of the Wall Street Journal this morning and look at really what I believe is truly the crux of the problem and taking a step back and looking at the big picture, and that is the profit motive in the whole managed care system.

For public companies, clearly, their primary obligation is first and foremost to their shareholders and not to the patients that they serve. I'm not sure that the discussion can go much further than that, frankly, if we're talking about for-profit companies in the managed care arena.

I do think, however -- I'm relatively new to San Diego, and I came from Massachusetts, where there are HMO's, Harvard Community Health Plan

the one I'm most familiar with, which is a nonprofit HMO, which did put all of its excess profits, so to speak, into outcome studies, into education, into education for patients, into education for faculty and staff and into the betterment of their patient population.

DR. ENTHOVEN: Peter?

MR. LEE: Were you finished with your remarks?

DR. FRIEDMAN: Yes.

MR. LEE: When you say outcome studies, do you mean the collection of HEDIS-type data, or do you mean specific studies they're demanding with respect to utilization data, patients being treated?

DR. FRIEDMAN: I'm talking about mental health, and the previous speaker was talking about managed care and certain illnesses are going to be treated.

When I began my training about 15 years ago, the standard care, for instance, was to hospitalize many patients who had a variety of mental health problems. And that was a standard procedure. That really stopped because managed health changed outcome studies showing that, for instance, 30-day hospitalizations had benefited patients.

Clearly, more studies need to be done to look at what kinds of factors and the kinds of management procedures will benefit patients and lead

to the best outcomes. The burden to provide those studies, though, is not being provided or the avenue to do those studies is not being provided by the managed care companies by and large. It's really put on the federal government to fund the studies through other funding mechanisms.

MR. LEE: So you are talking about the demands on individual providers or collected regular data --

DR. FRIEDMAN: No, I'm talking about in terms of figuring out truly what the best procedures are. The knee-jerk reaction of the managed care companies is if you don't have the data then we're not going to approve it. And frequently those studies take a long time.

DR. GILBERT: I'm a UCSD graduate well before your time. There's always been companies in health care for profit. We have for-profit medical groups. The UC system is trying to figure out how it's going to maintain its hospitals and its structures in this environment.

What's the difference that you see between all sorts of for-profit entities in the delivery of medicine vis-a-vis managed care? Is there some fundamental difference? Is it for profit in general, or does it apply to managed care differently? How do you see that?

DR. FRIEDMAN: I think any system that

collects money to provide health care, which basically managed care companies do, and takes some of that money away from the health care system in the form of extremely large salaries for managed care executives, to pay dividends to shareholders, where that money in some way isn't circulated back to the system to provide what companies are paying their premiums for, what people are paying the premiums for - and that is a provision of health care, health services, either directly through direct services or through funding studies, through education and so forth - I think is a fundamental problem.

DR. ENTHOVEN: Doctor, we have in San Diego, of course, some nonprofit entities. Kaiser Permanente and Sharp are nonprofit. And I was recently very pleased to read that the physicians and the hospitals at Scripps announced that they were going to get their act together, get organized, create a joint venture and compete as a nonprofit entity, which I thought was great.

And if these other guys are taking 30 percent off the top, why can't Scripps just knock their socks off? What's going on?

And that brings up another question, which is with the Sharp doctors who are taking care of Sharp patients and taking care of Pacificare patients, do you think they treat these patients equally?

DR. FRIEDMAN: First of all, I'm in no position to speak for what other physicians do or what goes on in other plans. You've asked me very large, broad, sweeping questions.

I think that one -- and I can speak best for an academic medical center. One of the other issues that I didn't touch on, though, that is on my list is the whole issue of adverse selection. And that clearly is a factor in the longer term survival of academic medical centers and how that plays itself out.

I mean, many -- in terms of the way centers market themselves to communities, how patients select which type of provider they choose, I strongly believe that academic medical centers have a much worse adverse selection for a variety of reasons, yet reimbursement is generally no different.

One other comment in terms of one of the issues that you're looking at, which is how managed care impacts or affects patient-provider relationship.

In the mail yesterday I received from the Robert Wood Johnson Foundation an initiative that they have just begun looking at exactly that question as it applies primarily to managed care. And you might want to link with them in some way to look at the initiatives that they fund and how that could affect their decisions.

DR. ENTHOVEN: Thank you.

DR. RODRIGUES-TRIAS: I have a particular interest in looking at the folks we normally don't see because they never cross our doorstep, and that I think is particularly true of the adolescent population. So I wonder if you think about the state role, what a state should be doing, maybe the Department of Health Services -- I'm not sure where this responsibility should lie. What kind of outcome studies would you be looking at that might give us some glimpses as to what we're not doing?

DR. FRIEDMAN: Well, clearly, things like immunizations for children and, for teenagers, hepatitis B - I mean, I think that there's some fairly concrete markers you can use. You can look at over time continuous rates of teen pregnancy, of STD's and so forth, a variety of different, you know, dietary habits. I think that those are fairly concrete markers that can be looked at.

Access to health care for teenagers is very complicated. And it really is something that is partially provider related, is partially patient related, partially system related. And it's fairly complicated. But I definitely think it can be looked at and is a vital issue in this whole debate.

DR. ENTHOVEN: Bud?

DR. ALPERT: I just want to clarify one thing. It's my impression that you feel that

clinical research is being impeded significantly by the managed care structure. Is that correct?

DR. FRIEDMAN: No, I never said that. My main point was that managed care companies are basing many of their policies and procedures and basically directing physicians how to act, what can be done, what can't be done, based on outcome studies, some of which don't really exist. And they're making decisions based on because-something-doesn't-exist-you-can't-do-it-that-way kinds of decisions.

What I'm saying is that I actually think that managed care has benefited health care in many different ways. The focus on outcome studies is actually very, very important. Prior to this focus, decisions were made really based on personal physician experience, anecdotal experience and so forth.

I think outcome studies are vital. My issue is that who's paying for those outcome studies. My issue is that really the burden to produce those studies has fallen back on other funding organizations, usually government organizations, federal organizations, foundations, but not the companies themselves that are asking for those studies.

DR. ENTHOVEN: Tony?

MR. RODGERS: Could you talk briefly

about what your observation has been about the effect on the actual training, residency training, what managed care is giving people to help patients, the opportunity for residents to train in that environment?

DR. FRIEDMAN: I think that there are great benefits. And I think that moving residents into outpatient settings, having them be much more aware of health care costs, resource utilization and so forth is very good.

The problem, of course, is that -- and this you sort of alluded to before. We are a training institution, and at UCSD we are competing against companies that don't do health training. And if we're getting the same reimbursement as, say, a Sharp is or some other institution and also at the same time we're required to do medical student and resident training in the clinic, we obviously can't be as productive in terms of patients seen per hour as other institutions.

So, you know, there are benefits to pushing more training out into the field, so to speak, and into the outpatient setting. But, again, who's going to pay for that, and how is that going to be reconciled within the whole system?

MR. KERR: Should the state and employers be paying you on a risk adjusted payment system?

DR. FRIEDMAN: Absolutely.

MR. KERR: And, if so, does the risk adjusted payment system exist that's good enough to do a decent job in that type of thing?

DR. FRIEDMAN: Not that I'm aware of. But I'm not an expert on that. But I would say that's something that needs to be found. Clearly, this is not just a UCSD issue. I think we should be providers of care for people with complicated, complex medical problems. That absolutely is what our role should be. But we need to be compensated in a way that's equitable.

MR. WILLIAMS: Yes. I really want to follow up on this outcome study question. It's a question I'm really interested in. And I'm with a health plan, and we have a process of developing medical policy. And I'd like your comment on the intersection between the lack of outcome study and kind of process we use.

We look at a procedure, for example, sometimes with treatment. What we would typically do would be to convene a group of subject matter experts, clinicians in that area. We would ask them to review the literature. They'd be independent people from academic medical centers, community based physicians. They would look at all the literature in a given area and come back and say we believe that this treatment is appropriate for these particular

conditions. So that the process is kind of arm's length.

Help me. Just repeat one more time how the lack of outcome studies would affect this kind of development of medical policy.

DR. FRIEDMAN: You know, I think that there are outcome studies for many procedures, diseases and so forth. I think it needs to be a continued process. You convene your panel of experts, who look at the medical literature for outcome studies. And we find many outcome studies that are funded by your organization.

The point is that the studies -- I mean, you know, health science is a continuum. Things are being -- there are new innovations all the time. What we need to do is to do this as a process. The real issue is who's going to fund the ongoing search for what are the best avenues of care. That's really my point.

MR. WILLIAMS: Okay.

DR. ENTHOVEN: Well, Doctor, you're suggesting that the HMO's are not paying for outcome research. In fact, I don't have a number in my immediate, but I think a year we had a visit at Stanford from Dr. Laretta, who is with Health Net now, and he spoke of a very substantial health services research budget and involved my colleagues in it and handed us reprints of articles, including

his own from JAMA, so forth.

And so they were saying they were being pretty serious about getting people involved in doing outcome research with them, maybe the not the dollar amount, but that's part of that 20 percent that they're taking off the top, of course.

Have you kind of surveyed how much they're spending? Because some of them say they're spending quite a bit.

DR. FRIEDMAN: Right. I'm sure that they are saying that. You know, I don't have any -- you know, again, this needs to be -- I can give you my anecdotal experience. I can give you my opinion of how I studied the issue in a -- you know, in a controlled type of way.

Now, no, I haven't -- though I do read lots of medical literature, and I can't remember any substantial studies recently -- well, you know, I mentioned some groups. Harvard Community Health Plan has funded quite a bit of health outcome research. I'm not aware of any studies that I have seen in the Annals of Internal Medicine, New England Journal of Medicine or JAMA in the last four or five months funded by an HMO. Maybe you have.

MR. RODGERS: I hate to put you on the spot, but this is too good an opportunity to talk to somebody at the front lines in academic medicine.

One of the consequences of managed care

in many of the states that use the managed care system, especially when you place Medi-Cal and Medicare in managed care, is a reduction of training opportunity but, more than that, the funding for residents. And it places the hospital or the academic center at the greatest risk because they have this extra burden of cost.

Is this a good way to control the oversupply of physicians, or are we creating problems for ourselves down the road because the market isn't necessarily in sync with where we're going to need physicians in the future? Can you comment on that at all?

DR. FRIEDMAN: Again, my comments would be personal observation. I mean, I do think that there are benefits. I think that there probably is -- clearly, there's a maldistribution of physicians and a maldistribution not only geographically but by specialty as well. The managed care system forcing the issue of more primary care physicians I think is probably very good. And, you know, where that's all going to settle out, though, I think is yet to be seen.

DR. ENTHOVEN: Rebecca?

MS. BOWNE: I just would like your reaction --

DR. FRIEDMAN: I mean, I'm saying that as a prejudistic primary care provider.

MS. BOWNE: I think one of the issues here is that the health maintenance organizations, in order to get accreditation from the National Committee on Quality Assurance, have to do outcome studies on population bases and justify that there have been improvement, but they're not necessarily published. So I think that they are ongoing.

And perhaps maybe a loop-in of some feedback of your comment that you can take is, as the managed care do that, because adolescents are an important part of the population, to do some improved numbers of outcome based studies on the adolescent population.

DR. FRIEDMAN: Absolutely. And they need to be -- you know, it's one thing to say that you're doing outcome -- I mean, they need to be evaluated and make sure that they're done methodologically. I'm not challenging that. But I think that getting them out there -- you know, there are many -- regarding adolescents, I mean, adolescents in some ways are the very easier population to have in managed care. They can be very undemanding. They don't seek services.

And so you see adolescents and how you provide those services, what kinds of anticipatory guidance, what kinds of questions you end up talking to them about, whether you truly provide preventive services for cigarette smoking, more education for

birth control or pregnancy prevention, more substance abuse education and all of that is something that needs to be quantitated and encouraged amongst your providing physicians also. Those are very, very easy topics to miss.

And although in theory managed care is ideal for teenagers because it puts a very large burden on prevention, I'm not sure that I've ever seen any study that shows that that actually gets done.

My other concern is that because of the kinds of problems that teenagers tend to have that are behavior related, other than sexual behavior, tend to be long term. I'm talking specifically about diet and exercise, tobacco and substance abuse. I'm not sure that managed care companies don't realize that those kids probably are not going to be in their managed care panels in 20 years, and I'm not sure how much of a burden managed care companies truly feel -- well, you know, I'm a provider on multiple managed care panels, and I've never seen anything come down telling me what kinds of guidelines to use when I see teenagers. And I see teenagers all the time.

DR. GILBERT: If managed care had anything to do with getting a person like you at UCSD, versus when I was there it was a completely specialty-based training where we studied bush Lime disease endlessly, that's a good thing.

DR. FRIEDMAN: That's because Dr. Nayan was still at UDSC.

DR. ENTHOVEN: Thank you very much, Doctor.

Next we're going to have Dr. Don McCanne, a self-employed California Physician's Alliance member, speaking on physician risk sharing and health care quality. Thank you.

DR. McCANNE: Yes, I'm Don McCanne, a family physician from San Clemente, California.

As members of this committee are well aware, managed care has been proffered as the free-market solution to the problem of intolerable escalation of health care costs. We the patients and the providers are very appreciative of the contributions of the members of this committee to the effort of assessing the impact of managed care on our health care system.

One of the most effective methods of managed care has been the introduction of risk sharing and a part of the individual physician through capitation agreements and through the establishment of reserve pools. Under such agreements, the physician's income is inversely proportional to the amount of service that is rendered.

With capitation, wherein the physician is prepaid for each patient assigned to him, any

service rendered consumes overhead expenses and thereby reduces net income. Also, ordering services paid out of reserve pools in which the physician has a vested interest likewise reduces net income.

This has been a very powerful tool of managed care. On the positive side, it has clearly decreased the rendering of unnecessary medical services. On the other hand, it has also been effective in decreasing the amount of nonessential elective but desirable medical services.

Most importantly and least desirable, it has been effective in increasing the physician's tolerance of risk taking with patient care.

Diagnostic and therapeutic interventions that have a lower probability of improving patient outcomes are frequently no longer included in the discussions of options that the patient may have because physicians, motivated by this financial disincentive, self-impose their own unspoken gag rule.

Only by removing these financial disincenives will physicians be motivated to fulfill the moral obligation to include discussions of such options as part of the informed decision process to which patients are entitled.

This has created the most serious fundamental defect in the managed care model. The physician is no longer exclusively the patient's

advocate for better health care. The physician now has additionally an adversarial relationship with his or her own patient, a relationship in which the physician's own financial well-being is in direct conflict with the delivery of optimum patient services.

Testimony to this fundamental flaw can be found by listening to conversations in any doctors' dining room or doctors' lounge. Physicians that adapted well to managed care have analyzed the defects in the managed care model and have come to the conclusion that the greatest problem is the patient. Patients are selfish and demanding. They want too much. They do not realize that the health care dollar is limited and we must stop wasting it on all of this excessive care.

Of course, traditionalists cringe on hearing these comments that seem to imply that the patient is the enemy.

What about quality? The managed care industry has professed an improved quality while controlling costs. However, there is general agreement that quality is very difficult to define and that it is nearly impossible to measure. Such measurements have generally been limited to parameters that have marketing value that reflect little on the true quality of the delivery system.

If we do not know how to measure

quality, then how can we be sure that quality will prevail in our health care system? Very simply, quality will prevail in a system in which the physician is exclusively dedicated to advocacy for better health for the patient. Quality can never prevail when increased profit drives a system designed to reduce services.

Physician risk sharing has been presented as a free-market solution to controlling health care costs. But do we really have a free market? The current solution has not allowed the patient/consumer and the physician provider free access. The market is now controlled by the managed care industry.

This solution has been outrageously expensive, consuming a major portion of our health care dollars. It has destroyed many of the values inherent in our traditional system. This industry has been far more wasteful and intrusive than any governmental bureaucracy has ever been.

We must abandon this defective concept of physician risk sharing. There are many other methods of controlling health care costs without resorting to such a discrepant model. We must abandon the fantasy that we can ever have a truly free market.

No matter how much or how little the government intervenes, we will always have elements

in the private sector that will attempt to control the market for their own personal gain. The secret is to design a health care structure in which personal gain drives the system toward the goal of providing optimum patient care. That is, we must reward providers for delivering the best care possible.

If we return the physician to the role of being exclusively the patient's advocate, then what will prevent us from returning to a pattern of escalating health care costs? The answer is found in the very simple concept of a global budget. We are already delegating 14 percent of our gross domestic product to health care, far more than any other nation, far more than enough to provide quality health care for everyone.

Although the concept of a global budget is ideologically opposed by the purists supporting the free market, the budget process is a very effective tool of the private business sector. Every business functions with a budget. Everyone understands that resources are always finite and that expenditures must be limited. In our own personal budgets, we adhere to these principles. Now we even expect the government to operate on a balanced budget.

If the budget process is effective for our businesses, our homes and our government, then it

should also be effective for our health care system. Thank you.

DR. ENTHOVEN: Thank you, Doctor.

DR. GILBERT: Just a couple of questions. One is, if you accept the premise that capitation would motivate individuals to provide the most efficient and least - but not in a pejorative sense - care, wouldn't it drive physicians to preventive activities?

I'll give you a couple obvious examples: Doing pap smears on a frequency that's avoided to have to do a culposcopy, bone scans, et cetera, et cetera; number two, smokers or individuals with health behaviors that clearly lead to more accutely exacerbating their asthma, bronchitis, et cetera, et cetera. Does it provide that incentive at all, in your view, or is it mainly on the other side, just as purely utilization?

DR. McCANNE: I see that as a marketing phenomenon of the industry that preventive services have always been provided. Now, much of the various surveys that are done to determine quality measure those few things that the managed care entity knows is going to be measured, and then they present those statistics. But it doesn't get around the problems that I mentioned. That is not where quality comes from, counting pap smears. Pap smears are obviously very important, but that is not -- that will not

define a quality system.

DR. GILBERT: So you don't believe that -- because there's many other examples where providing a preventive service, stopping the individual from smoking, could probably have more impact than utilization of medical care services, as an example, than many other interventions. And our system has generally not been focused on really working on -- our immunization rates are 50 percent for children under the age of two.

So how would you propose trying to drive the incentives in a way that would truly make a difference in terms of people's health and utilization?

DR. McCANNE: Well, you know, those are -- you know, again, I'm a family physician, and I certainly provide immunizations and so forth. In my practice I have no idea what the rate is because I'm not that well computerized, plus, you know, the children coming and going to different clinics and so on.

But this is not unique to managed care that you encourage immunization programs. I certainly encourage immunization programs. I bring the children back for their -- you know, make the appointment when their next immunization is due. I think we all believe in the real preventive medicine services and practice them.

And I really don't believe the marketing -- the managed care marketing claims that they're preventing more services than we -- more problems than we've been doing in the community anywhere.

DR. ENTHOVEN: Dr. Spurlock?

DR. SPURLOCK: Thank you, Doctor. I appreciate your comments. I'm interested. You used the word global budget, and I want to explore that a little bit more because you talked about that at length. I think you laid out very clearly what the concerns and the ethical quandary is over individual capitation. I am an individual physician who has to deal with a budget and a quandary of what can happen.

Seriously, I'm interested in finding out how big a global budget you would need. Do you need it on a national scale? Some argue that large groups of physicians, in the 300, 400, when you get to budgets of that size that you take the individual physicians out of that moral quandary with that individual patient and you can still allow the prepaid health plan which that global budget is on.

So I'm interested in how you would would draw the line, how global it needs to be not to deal in the individual quandary.

DR. McCANNE: Well, I certainly have a strong personal bias. As I mentioned, I'm a member of the California Physicians Alliance, which is the

California chapter of the Physicians for National Health Program. And you probably read some of their literature and articles in the New England Journal, so forth. So my own personal opinion is global budget is 14 percent of our gross domestic product.

DR. SPURLOCK: But you're not per se opposed to the concept of prepaid, budgeted care? You're just opposed to --

DR. McCANNE: I'm not opposed -- if you're talking about capitation, I'm not opposed to capitation of large provider groups, Kaiser. That's certainly a very ethical model. You know, the Kaiser physicians are compensated in an ethical manner.

But I think when you -- when you place an individual provider on a capitation basis for compensation that you have created this horrible ethical dilemma. And this thing is very real. I mean, I mentioned the discussions in the dining room and the doctors' lounge and so on. These are often loud arguments so people can hear them in the hallways, I'm sure.

But there is a tremendous conflict within the profession now as to whether on the one hand you have individuals like myself who think this is a horrendous thing and then on the other hand you have individuals that are talking about the great opportunity that this offers. And then they go out and they get in their Lexus or their Mercedes, where

I drive a Toyota.

DR. ENTHOVEN: Doctor, could you just explain that in a little more detail? My impression of most of what's been done by the Health Net, Pacificare, so forth, is that they contract with fairly large medical groups or IPA's. And usually the contract is the doctors will do all the doctoring for, let's say, $45 per person per month or something --

DR. McCANNE: Yes.

DR. ENTHOVEN: -- perhaps adjusted to age and sex.

And then with dollar limits, to limit the doctor's risk, we have a budgeted amount for hospital. And if you bring in the hospital cost below that, the medical group can keep half the savings until it's reached half it's -- you know -- a quarter or like ten percent. So you can save -- you can gain $4 per person per month if you do your job, or you can lose $4 per month if you overrun on the hospital.

So I've limited it, but that seems to me like the typical arrangement in California. But you're describing something rather different, which is an individual doctor who is -- when you say capitated, I presume you mean at risk for total services or for a larger set of services. Or do you mean just is paid a per capita amount for the primary

care services, as is the case in British National Health Service? To which were you referring?

DR. McCANNE: What's very, very common in California is the physician is paid so much per month for each patient that has selected him as the individual provider.

DR. ENTHOVEN: For doing primary care services? Isn't that exactly the British National Health Service who does that?

DR. McCANNE: That's the British system of socialized medicine. We're talking about private sector health care here.

DR. ENTHOVEN: But the payment is the same. That's just saying you're on salary and the salary depends on the number of patients on your panel. You're not saying the doctor's at risk for the other cost?

DR. McCANNE: It's not the same as salary. When you're assgned so many patients, that determines your paycheck. Then since you're in private practice, when you render services, you are consuming overhead expenses.

DR. ENTHOVEN: Okay. Just to be clear then, what you're saying is an arrangement where the primary care physician is paid so many dollars per person per month for primary care service, and that's it, no at risk for the hospital or -- you consider that to be unethical?

DR. McCANNE: Yes.

DR. ENTHOVEN: Okay. Thank you. Any other questions?

DR. ROMERO: I have a question, Mr. Chairman.

DR. ENTHOVEN: Okay.

DR. ROMERO: Dr. McCanne, thank you very much. Your expression was a contrary view compared to some I've been hearing lately, which have been mostly along the lines of, to be colloquial about it, the guys in the suits are rationing care, these decisions should be shifted to the care providers themselves.

And you have made an eloquent description of the kind of moral, ethical dilemmas that occur when you are asked to make those tradeoffs.

My question, though, is, if you have some other financing structure like a global budget, I think you're just relocating those decisions to somebody else, are you not?

DR. McCANNE: No. The point I'm making is that you have to remove the ethical dilemma from the physician.

DR. ROMERO: I hear that. And by so doing, you know, unless we spend an unlimited amount on health care, somebody is going to be having to make decisions about whether a particular procedure,

you know, has medical benefits that are commensurate with its costs.

DR. McCANNE: If you're referring to the government involvement making the decisions --

DR. ROMERO: I mean, my point is that as long as there's a fixed budget I think somebody ultimately has to make that decision. And, if not the medical practitioner, I assume in a global budget it's somebody else, isn't it?

DR. McCANNE: It's not somebody else. It's the patients and the physician working together. We need to reestablish a partnership between the patient and the physician to attempt to attain the very best care possible for that patient.

Now, finding a budget is a very frustrating experience. And to try to get services that are limited by a budget is an annoying thing.

DR. ROMERO: Sure.

DR. McCANNE: But that's a far better model than what we have now.

DR. ROMERO: But if I am understanding you, then, in that circumstance there's some keeper of a budget. And the physician goes to that keeper of the budget as an advocate for the patient and says I think this care is worthwhile and worth its cost. And some keeper of the budget makes a decision, by your argument or counter-argument, that it is or it isn't; isn't that true?

DR. McCANNE: It's not, no. I don't perceive of a system using a global budget as having some kind of a health care czar or some kind of --

DR. ROMERO: I'm not making any statement who that is, whether it's a government person or a plan person or a medical director. I'm just trying to understand how -- you know, how you design a system where there isn't a person or body that plays that role.

DR. McCANNE: Okay. You still maintain the private sector, private physicians, private hospitals. Many of them nonprofit - they don't have to be nonprofit - maintain an insurance industry that serves the traditional function of claims processing or distribution of capitation funds to larger provider groups.

But those entities now, instead of -- as it is in a larger and larger percentage of the market, instead of having the primary obligation of that entity being to enhance shareholder value, the primary responsibility of that entity should be to improve patient care --

DR. ROMERO: Okay.

DR. McCANNE: -- recognizing the limited funds.

So you still would have a private insurance industry doing these things but should operate on, personally, I believe, a nonprofit model

so that they don't have to be concerned about the interests of the shareholders.

DR. ROMERO: Okay.

DR. McCANNE: And, also, I think we need to get rid of, you know, some of the other wastes that have occurred, such as the outrageous executive compensation packages and so forth.

DR. ROMERO: Thank you.

DR. ENTHOVEN: Thank you, Doctor. I think we have to move forward. Just take one more question on this one. Two; Ron, and then Clark.

MR. WILLIAMS: Yeah, I have one question, Doctor, regarding the quality issue. And I have looked at certain research done by some of your colleagues who have studied peer review journals. And the outcome of findings of those indicate that HMO quality care is equal to or better than fee-for-service. And this looks at studies that have been published in the New England Journal of Medicine, the Journal of the American Medical Association. There's a whole -- I'd just be interested in your response.

Are you familiar with those studies? Do you agree or disagree?

DR. McCANNE: I think the overwhelming evidence is that there is no increased quality by those entities unless you're counting pap smears or counting immunization levels that are in a central

computer. But I don't think that those studies have really documented a superior quality.

In fact, I think that there are plenty of studies that have shown otherwise, that the quality is higher in -- well, for instance, the nonprofit HMO models, when they compare them with for-profit -- that's not quite answering your question but --

MR. WILLIAMS: I'm just here looking at the data that basically says something very different. And maybe later I can share it with you and we can have a chat.

DR. ENTHOVEN: Doctor and colleagues, what I'm worried about is we have six more people, and we have less than 60 minutes. So do we have a little global budget last question here or --

MR. KERR: I'm not a global budget, but we've got a bigger question. I'd like to ask just one for a quick response.

Would the problem be resolved if physicians were based on performance for what they did for their patients? It's being experimented with some groups now but wouldn't necessarily fall automatically under a global budget.

Shouldn't physicians be paid like other people, based on how good a job they do? In other words, if you did a better job in detecting cancer at stage one, if you were a surgeon and treated someone

and had a lower mortality, if you were able to keep asthmatics out of the hospital better than average, if you had higher patient satisfaction, shouldn't they be paid based upon what they actually did? Wouldn't that solve a lot of problems?

DR. McCANNE: Yes, provided you don't use utilization rates, which would just drive up the costs again. Yes.

DR. ENTHOVEN: Thank you very much, Doctor.

We're going to hear from Dr. Tom Houghton. Is Dr. Houghton here?

DR. HOUGHTON: Yes.

DR. ENTHOVEN: I'd just ask -- again, I'd like to follow the format if we can of no more than five minutes for prepared remarks.

DR. HOUGHTON: I have exhibits. I hope everybody has them.

DR. ENTHOVEN: We're going to.

DR. HOUGHTON: I'm Tom Houghton. I have 40 years' experience as a dental specialist. I heard about this committee's hearing Wednesday, and I flew down here from Sacramento. I think this is a matter of urgency.

We have a different problem with dentistry as -- well, similar as medicine and the for-profit plans and the nonprofit plans. In the Sacramento pilot program that I experienced in the

last three years, the for-profit plan has slowly monopolized the patients. The enrollment agency gives them a primary group, a larger group than the others. There is a lot of discrimination. I don't know whether it's political or what the problem is.

The children are not getting care. The care they're getting is not quality care. And as a specialist, I see this day in and day out.

We have a problem with hospitalization. We have a lot of children that are crack babies. We are dealing with Denti-Cal patients. They come in abused children, traumatically, mentally and medically compromised, disabled. In an office setting we cannot deal with treatment for these patients. They have to be hospitalized outpatient or maybe even GA in some other office. They have to be taken care of. Some of these plans do not have the facility for such. They do not have a budget for such.

I have in that first exhibit eight patients of one plan - I won't say who it is - that are abandoned for almost a year. They're just shelved because there is no budget; therefore, there's no treatment.

I have on the second exhibit some improvements that I feel that the program should encounter, think about in the coming years, at least in this next year, where we have more clinical

practitioners involved in authorizing care for these children. We've run into bureaucrats authorizing treatment, dentists who have never practiced authorizing treatment, general practitioners who are not pediadontists authorizing treatment or not authorizing treatment.

There needs to be the quality as far as care is concerned for these children. They are specialized children. They're not just your normal, everyday blue-collar-worker children. These children need care. They need access to care. They're not getting it in the pilot program.

And I feel that we can go forward if we do more preventive measures, if we have school surveys, we have general examinations every day for kindergarten through sixth grade, if we have sealings that are given on these teeth on these kids who do not brush, who do not have a toothbrush, who don't eat the regular nutritious foods that your kids eat.

These kids eat fast foods. They eat candy. You know what these kids get. And then they have -- it goes into abuse. These parents have these children in pain at night crying and causing trouble. And pretty soon there's some sort of restriction on these kids, whether it's an abuse or what the problem could be. It's promoted from a toothache and an abscess, not just one. I've seen kids with twelve and twenty teeth. That's it.

DR. ENTHOVEN: Thank you very much. Any questions?

We'll make copies of this available to the -- all the members of the task force. Thank you very much, Doctor.

Our next speaker will be A.D. Krems, M.D., Ph.D., speaking for California Seniors, AARP Health Care Reform.

Doctor?

DR. KREMS: Well, thank you very much for the task that you're trying to achieve and -- which is your assigned task from the governor. It's a toughy.

I want to apologize for the few people from the public who have come here tonight, but I want to remind you that Friday night does not attract elder folk. They don't travel at night. And Friday night is a time when you can't expect Jewish people to come. And Friday -- not on Friday. Come on. People go home. They rest. They do all that.

But thank you for working so hard through this ordeal. You covered a lot of topics. I want to cover one that I didn't mention there because you've mentioned it so often, and that's outcome studies. Medicine is loaded with them.

125 or so of medical schools don't teach their subjects without knowing the consequences of what the heck they're doing. They've been doing

that a long time. Unfortunately, a lot of those aren't critical. A lot of these are impressions. As someone said, they're authoritarian remarks about how things should be managed. And then all of a sudden we get thrown in here a brand new idea. Brand new, hah. That outcome studies will tell us the answers, well, try and get them.

The Veterans Administration has to pool tens, hundreds of hospitals to get enough population to study a problem. The federal government has been studying this a long time in a number of areas. And there is information available, but it comes slowly.

Now, how do the managed care people and how does any doctor really decide what's appropriate care? We make it a scientific, educated guess about what is the best based on our experience, based upon our training, based upon what we read. And that's the best we can do. And it keeps on changing because there is progress. It adds new ideas.

Health care is a very complex matter for any person. It's not easy. But managed care people think they're solving the problem in a businesslike fashion - and I respect them for this - by hiring or contracting with certified professionals. That ought to mean by implication a pretty good standard of practice. And I think that's sound. But that doesn't take care of across the board.

And now, Dr. Enthoven, you have mentioned how wonderful we are here with our medical school system and our Kaiser system and our Scripps system and our Sharp system. Those are battlegrounds here, all right, for practice. And they will be engaged in this.

And when Columbia HCA comes in, it's again another threat because they're taking 25 percent away from service to people. And they're crying that -- they claim that they're doing a very good job. Well, we have no evidence of that. It's hard to get that evidence.

But I hear from my fellow elder folk and from people who consult with me - because I am a retired physician, and they do have problem here and there so they run them by me - things aren't so good out there in these programs.

Number one, there isn't enough time for a doctor or a nurse practitioner or whoever sees them to really spend some time with them. Remember that one of your charges is to protect the public from the managed care program. You have it because there have been a lot of complaints and a few abuses. So there is one of the areas where come up with something, please. We need help. The public needs help.

And when you with your study committees get to it and come up with something, then maybe you can advance the program. That's what your charge is.

I have a suggestion to make -- well, before I talk about that, let me talk about prevention, which is name dropped. Nobody has any information about how good preventive measures are. There are a few token ideas, but nobody has it. And yet the managed care people claim -- and the HMO's, health maintenance organizations, claim they're preventing things, thus saving money down the line against the expensive costs of medicine.

Well, my point is, if it's prevention, save the life. Save the way of life. It will cost less too if you do that. But number one is the quality of care, the quality of life of the person, the health of the person, the lack of illness, if you will.

So enough for prevention. But what I have to suggest here is to you. I hope you come up with some kind of a recommendation that will apply what we have here well established - and it is existent across the state - and that's the ombudsman program.

The ombudsman program is one that protects the public against the government in Denmark. But here we've applied it to long-term care very effectively in this case and very effectively down here. We have three hired people and two assistants paid by the county, trained 125 people who are volunteers who go -- who accept the complaints,

who study them out, don't have any kind of clout except that they are agents of the county government investigating a complaint.

Do you know what it means when someone looks over your shoulder at what you're doing? That's in effect what the ombudsman program does. It adds a new dimension to health care in long-term care. And it's got a track record that's very good.

So what I'm suggesting is that you study that out and I hope come up with a plan that could be applied to all of health care, not just in the long-term care, convalescent hospital settings or board-and-care areas or places like that, residential hotels, but in the doctors' offices, in the hospitals, an added facility, a resource for the patient to examine, complain, to inquire, to improve the health care of the person that's involved.

So that's my positive suggestion. Please take it up from there.

DR. ENTHOVEN: Thank you, Doctor. Questions? We have about three minutes.

I was a little puzzled in the beginning, Doctor. You said medicine is loaded with outcome studies.

DR. KREMS: Yes.

DR. ENTHOVEN: In the medical school I taught in, that wasn't the case.

DR. KREMS: Well, I think you're

mistaken about that. Stanford certainly has plenty of outcome studies that it relies upon to teach its students and graduate students. So please don't say that.

DR. ENTHOVEN: No, but I'm speaking of Wenberg studies and all the discussions about medical uncertainty, wide variations in practice. My colleagues complain regularly about the absence of outcome studies.

DR. KREMS: Well, there's a dearth of them. Of course, it's a difficult thing to achieve. But let's put it this way. Let's take a new drug. How does it get on the market? It has to be established that it is safe --

DR. ENTHOVEN: Right.

DR. KREMS: -- and effective.

DR. ENTHOVEN: You're right. Okay.

DR. KREMS: And through several different levels.

DR. ENTHOVEN: You're right. For pharmaceuticals there are outcome studies. They have to.

MR. RODGERS: I'd just like to go into a little bit about the ombudsman program that you talked about. Do they provide training, and are these individuals paid by the county?

DR. KREMS: The training of a layperson who has the interest and who is acceptable is trained

by the county, first of all, for a basic training. And then after basic training they are supervised by those three to five people in the county. And they have to take updates, which, by the way, I hope you will have some recommendations for personnel to be trained in managed care arrangements. They should have that kind of updating training. It would be wonderful.

On being paid, the only pay that they are allowed is for their transportation costs. I don't know what it is per mile at this time, but that's all. It's a volunteer program, tremendous asset.

MR. LEE: Thank you, Doctor. Being someone who is working with people for ombudsman for managed care programs, I appreciate your recommendation very much.

But I'm curious from your experience what you hear from the ombudsmen in San Diego about what experiences they're seeing of the seniors in managed care. Because one of the things I've heard some of is a lot of long-term care -- ombudsmen are seeing issues presented by people in long-term care facilities that are overlapping issues, that are the push and pull of, oh, this isn't long-term care.

I'm curious if you have observations of seniors in long-term care facilities as it relates to managed care services.

DR. KREMS: No, I don't. I don't have that, and I'll tell you why. Long -- the managed care programs don't budget for long-term care. They avoid it like poison. They don't even get involved in the day care programs, which are less expensive than the institutionalized care. But, you know, that's a business matter.

Also, I want you to know that, like with the Kaiser program, a lot of the managed care programs are for younger people, employed people. Now, let me tell you about the managed care that's sold to the elder folk who, my colleagues -- it replaces Medi-Gap insurance. Da-da, they get $5,000 plus or minus $4,500 or $1,000 a year from the federal government to take care of all costs.

Who goes to them? People that want to be sure that they're not going to be financially depleted, basically, healthy adults at my level. Sick, sick people don't go there. They know they're not going to get the care. They don't touch it with a five-foot pole.

But do I have information about it, what happens in the nursing homes? No, because I don't think there is very much.

DR. ENTHOVEN: Thank you very much, Doctor.

If my colleagues will allow, we'll move to the next one, Dr. Stuart Scherr, who is retired.

Thank you, Doctor, for coming.

DR. SCHERR: I am a certified doctor of internal medicine. I've practiced in Oceanside, which is in the northern part of San Diego County, for 31 years. I retired four years ago because of illness. For the past year I have been an advocate as a private citizen to try and keep our Tri-City Medical Center independent of both for-profits and not-for-profits.

My expertise is basically as a layman on this issue, and what you hear will be relatively unsophisticated and without supportive data except from the Wall Street Journal, the local newspaper and the San Diego Business Journal.

It is my contention that HMO's in the free marketplace are contributing to the bankruptcy of many of our nation's hospitals. Hospitals are forced to accept contracts to fill their beds at reimbursement levels below cost. The HMO's are thereby, in my opinion, contributing to the rapid acquisition of hospitals by Columbia HCA and other for-profits.

The hospital cuts down to bare bones. The hospital still can't break even. The hospital sells to a for-profit.

The for-profit takes 15 to 20 percent off the top, to say nothing of CEO bonuses from an already slimmed down institution. The profit is only

marginally from economy of scale, so-called integrated delivery systems. The bulk of profits come from inadequate staffing, deterioration in quality and quantity of supplies and dirty hospitals, contrary to the full-page ads in two of the dailies that I subscribe to and one weekly, all that came out within two or three days of each other this week.

The following is a short letter to me from a nurse who formerly worked at Tri-City Medical Center in Oceanside, with which I was associated during my entire 31 years of practice.

Quote: When I left Tri-City, I became a travel nurse. And over the past six years I have worked at 20 hospitals in eight different states. I have worked at a couple of for-profit hospitals and would like to tell you about my experiences there.

First of all, the staffing was very poor. I worked twelve-hour nights, and the usual patient-nurse ratio is twelve to one. Acuity played no part in staffing. My worst night was when ten out of my twelve patients were on various kinds of isolation. I consider myself an organized person, but there is no way you can do proper nursing care with that many patients.

A nurse's aide was usually assigned to do your vital signs and answer your lights. Most of the nursing care was done by her. I was lucky if I could get the medication passed, keep the IV's under

control and do the charting. Our equipment was old and scarce. IV pumps were available only for people with central lines and special medications requiring the use of pumps.

Supplies were always short, and we would have to go from floor to floor trying to find some area that had what we might need. Most of the units had locks on their supply room doors so that other units could not steal from them. We often did not have linen to use for the night shift. It was not unusual for the linen carts to be bare, especially on the weekends.

Some of the services were contracted to outside companies. Housekeeping was one of these areas. The hospital was not clean. The dirty utility room was so foul with overflowing trash bins, linen carts and patient trays that you could scarcely stand to go in it.

My saving grace was that I was on a short-term assignment and did not have to put up with it for long. I have talked with other nurses who have worked at for-profit hospitals, and they have had similar experiences.

Tri-City Medical Center is a great hospital. Please keep it that way. If it isn't broken, don't fix it. Remember that if you affiliate with a large conglomerate whose only goal is to make money, Tri-City will no longer be our hospital (the

community) or your hospital (present and future employees) but their hospital to do with as they will.

This experience was at the Columbia HC Hospital in Las Vegas, one of two, I might add. We have placed responsibility for care of our ill in the hands of the lowest bidder. Market forces are detrimental to the health of our most vulnerable citizens. HMO contracts with hospitals should be regulated to ensure that hospital reimbursements cover their costs. Thank you.

DR. ENTHOVEN: Thank you, Doctor.

Questions? Dr. Alpert?

DR. ALPERT: I feel compelled to make a comment. It's not a question. And the reason I do is that the reality is that the great majority of this task force doesn't spend every day in a hospital. It is not exposed to the kinds of things that we just heard testimony about. And these are not isolated anecdotes that are just sour grapes that people are saying. These things are occurring.

I have a friend who is an excellent physician who told me that she would not have a family member of hers in a hospital in which she practices without staying there with her and for the kinds of reasons that you're saying.

And there's a reason that there's a public outcry. These are not isolated anecdotes.

There's a mounting force that's creating these kinds of letters. This is not a person who is just bitter, the nurse who wrote this letter. And I think it's important that we pay a lot of attention to this kind of testimony.

DR. SCHERR: My conclusion about Columbia is that they will do whatever they need to to better their own situation. They will give adequate services where they are open to public exposure, especially in university hospitals. They will give adequate reimbursement to hospitals where they are in the marketplace to add more hospitals.

But they are in a situation where they are largely taking over hospitals that have already contracted themselves in order to try and stay afloat and then could not succeed. And after that they then take another 20 percent of profit out.

I think it's a dreadful situation. I think that, if I may mention another name, Tennant does exactly the same thing. Beyond that I have not really investigated.

MR. RODGERS: Doctor, are you -- have you observed the regulatory oversight that hospitals go through, licensing? I know that Tri-City is Joint Commission accredited, et cetera. Do you feel that's adequate, or does there need to be an integrated agency both over the managed care organization and the hospital - because the two are much closer in

relationship - and maybe even the physicians' relationship to oversee what's going on with those relationships?

DR. SCHERR: Well, I feel that any hospital can respond when it gets three months' notice to prepare for an inspection. I think that unannounced inspection would be worthwhile. I think that in order to appreciate the care that patients get that the nurses should be investigated, should be inquired upon on an unannounced basis.

I know that Columbia can prepare a set of nurses to receive a bunch of doctors from a hospital which is a potential purchase for them. But I've heard from other hospitals in other areas that the care is equivalent to what I gave you today in Denver hospitals, in San Jose hospitals acquired by Columbia and several hospitals acquired by Tennant.

DR. ENTHOVEN: Thank you very much, Doctor. We're going to have to move on. We now have four left in thirty minutes so I have to tighten this up a little bit.

Ruth Rahenkamp. Ms. Rahenkamp, thank you for coming.

MS. RAHENKAMP: Thank you.

DR. ENTHOVEN: I'd appreciate it if we could try to keep the presentation brief.

MS. RAHENKAMP: I just have one page. First I'd like to begin by saying that I have had

access to physicians, good physicians, and I've been very happy with my doctors. My particular area has been manic depressive illness. I was diagnosed 20 years ago. And since coming to San Diego I have had to deal with managed health care companies, and I've been fairly unhappy with it.

At times when I'm in a manic situation and I'm experiencing overwhelming confusion, anger and frustration, my psychiatric visits are doled out in a way that's a business oriented way. I get two visits here, four visits there. It's being judged by someone who has never met me, has no sense of my own needs. And this is one of the issues that bothers me.

On more than one occasion I've been told that my psychiatrists were no longer eligible through the policy. And in October of this last year, when I was in the midst of a crisis, I was told that my entire psychiatric team was no longer eligible for care. I mean, this caused me a great deal of pain, and I -- a family member had to intervene on my behalf at that point because I just was in no position to manage it.

My psychiatrist has been asked by the HMO's to limit my appointments with him to med visits. This type of visit does not permit the psychiatrist the time that's required to really know and understand the patient's needs. If you go in and

you see a doctor for ten minutes and he says how are you doing on this drug, well, it's not a simple thing. The subtleties of medication are odd.

I have experienced myself side effects that I had no idea were side effects, and you don't get the -- the support you need in a ten-minute med visit.

Also, the thing probably that I like least about managed care is the extent to which there's a different ceiling for mental illnesses than there is for any other illnesses. I have bi-polar illness. It's a legitimate disease, and it's a chronic illness. It's not unlike asthma. I'm never going to grow out of it. I'll always need medical treatment. And by introducing barriers to the attainment of the health care I need, the managed care has made the process of getting care even more difficult. And it's when I need the care most and my needs are the greatest that the barriers of managed care are at their highest.

When we look at the cost of managed care, I think if you look at the cost to the organizations themselves, perhaps the cost of mental health care has gone down. However, when we look at the cost from a societal perspective, they've indeed gone up.

And in my own case, I've had a very difficult time over the last four years, and I've

been hospitalized once. I have lost probably six months, perhaps more, in work time. This is time that was paid for by my company and time that was paid for by the state. It wasn't paid for by the HMO. And it -- with additional -- with additional time with the physicians, I don't believe that I would have been hospitalized. And it upsets me a great deal.

And I thank you all for your time.

DR. ENTHOVEN: Thank you very much for coming.

Yes, Dr. Spurlock?

DR. SPURLOCK: Thanks a lot for testifying. When you were in one of your manic phases, when it was as terrible as you described earlier, which sounds horrible, you said it was doled out as to the number of visits that you could see. Did your physician or psychiatric team ever offer to see you either for no charge or perhaps an additional charge outside of the plan?

MS. RAHENKAMP: My psychiatrist did. I mean, actually, he spoke here earlier, Dr. Munos. He did not charge me for visits that weren't covered by my insurance. My psychiatrist accepted a rate from me at the same rate the insurance company was paying him, which is at $30 per visit, which is much lower than his normal rate to patients.

So, yes, I mean, I think that they have

really gone all out to help the situation.

DR. SPURLOCK: So you both purchased and received at no charge additional care; is that right?

MS. RAHENKAMP: Yes.

DR. SPURLOCK: Thank you very much.

DR. ENTHOVEN: Thank you very much.

MR. LEE: Could I --

DR. ENTHOVEN: Oh, sorry.

MR. LEE: -- ask a quick one?

DR. ENTHOVEN: Okay.

MR. LEE: Thank you very much for coming as well.

In terms of you noted in one of the problems you were having a family member needed to intervene, I'm wondering what they did that jumped through the hoops and if you thought about going to the state or any regulatory group for assistance and, if not, why not.

MS. RAHENKAMP: Well, first of all, my sister intervened on my behalf. And she basically got a hold of the insurance company and said that she was calling from Alabama and her sister needed their care and she wasn't going to stay off the phone until they gave it to her.

And we're a pretty tenacious group in our family. I mean, I am myself. And I believe that I've gotten more than the average patient with a

psychiatric illness would have out of the insurance company because I've gone after them.

And in terms of my going to the state, I think I'm just getting myself together to a point that I feel that I can. And it's one of my goals at this point to do just what I'm doing now.

MR. LEE: Thanks very much for coming.

DR. ENTHOVEN: Thank you very much.

Next we're going to hear from Mark Jennings, California Nurses Association. In fairness to the remaining people, we'll try to --

MR. JENNINGS: I will be brief. I did not anticipate speaking tonight even.

My name is Mark Jennings. I am with the California Nurses Association here in San Diego. I represent a number of hospitals in the San Diego area, the largest of which is the UCSD Medical Center at Hillcrest and Thorntorn.

There's been a lot of discussion tonight about quality of health care and measuring it. And there's also been the suggestion that perhaps the solution to that inquiry might be to look at nurses because nurses are ones with at the bedside and the nurses are the ones that see what's going on.

I anticipated having two nurses here tonight. One of them's mother-in-law is in the hospital. She took a turn for the worse. And the other nurse is home with a fever. So I didn't

anticipate speaking tonight.

What I'd like to do, though, is provide you with a preview of what nurses will tell you as you travel throughout the state. Because as you go from city to city, the California Nurses Association will be providing you with nurses who do bedside nursing care.

And what they will be telling you is that the quality of patient care is declining. The staffing ratios are increasing. And the acuity level is increasing. And that's real obvious, I believe, because as the HMO's and for-profit health care push people at home to do their healing, the people who are remaining in the hospitals are sicker. And at the same time, there are fewer nurses to take care of them.

Managed care is forcing nurses into a conflict of interest between their lawful mandate to advocate for the patient by the Nurse Practice Act and their own livelihood.

In the last six months at UCSD our nurse professional practice committee has filed four complaints with the Department of Health Services. Each one of those complaints has been sustained by a citation from the Department of Health Services. All of them have related to staffing. That is what we've had to use for leverage in order to try and maintain the quality of patient care at the UCSD Medical

Center.

As for-profit corporations move into health care and attempt to turn it into an industry, the principles of industry are imposed. And that may not be a problem if you're manufacturing cars or toothpaste. But when your product is health care, nurses are seeing a decline in quality.

People have alluded to the fact that you're not making a profit if you're delivering health care. So the push is to not deliver the service.

That concludes my remarks.

DR. ENTHOVEN: Thank you, Mr. Jennings.

Questions?

Have you been able to separate out in your mind the effect of the Medicare payment system, which is also squeezing hard on hospitals, versus the managed care?

The thinking that's going on, I think, is that the entities that pay for care, whether it's government or private sector, through HMO's, PPO's, they're all pushing back on the costs because there's been a widely-held view that the costs are too high, taxes are too high and so forth. So it's not -- the point I'm making is it's not just HMO's. All these forces are pushing back.

MR. JENNINGS: That's correct.

DR. ENTHOVEN: In other words, Medicare

looks about the same as HMO's.

MR. JENNINGS: From my perspective, I believe it does. Because I'm looking at it from a perspective of how the quality of care is being delivered and the quality of that care. So, I mean, whether the impetus is from making a profit or just to make -- you know, maintain costs, there's still the impetus there to deliver less services.

DR. ENTHOVEN: Yeah. Any thoughts about how effectiveness or efficiency can be improved? I mean, with a budget deal in Washington now part of the deal I guess they've made, they're going to cut a hundred billion dollars out of what they pay doctors and hospitals. So the trend is, if anything, to get worse.

MR. JENNINGS: Do I have any suggestions?

DR. ENTHOVEN: Yeah. How do we --

MR. JENNINGS: As you know, the California Nurses Association is probably the largest organization to support single payor initiative in 1994.

DR. ENTHOVEN: The single payor for Medicare is cutting back just as hard.

MR. JENNINGS: Well, that's true. But, I mean, I'm coming from a basis that they are trying to cut back, but they're still delivering health care to their entire population, say, for example, in

Canada, which is something that we're falling far short of.

DR. ENTHOVEN: Thank you very much.

Next, Dr. Fred Baughman. And, Dr. Baughman, thank you very much for coming.

MR. BAUGHMAN: I'm pleased to be here. I heard of this committee meeting or hearing at a late hour. I'm delighted to be able to present.

I have been a neurologist and pediatric neurologist in private practice for 33 years, retired for three years now. And I have been a chief of staff in a corporate for-profit hospital. And I have academic and research credentials as well.

My remarks are as follows: Without proper diagnosis, the prescription is doomed to fail. In the May 1996 California physician Robert Allen, M.D. wrote, "I am sick of the pious bleatings of our medical societies regarding physicians' economic futures. Not only do we not have control but we will never regain it. We have allowed medical schools to overproduce physicians. We have allowed residency programs to overproduce specialists."

He neglected to say that patients too had lost control. No matter how the perpetrators try to disavow and disseminate blame, all that has followed the U.S. health care crisis and managed care as well are mere epiphenomenon. I know. I started practice in 1964. In 1965, with the populace well

cared for by 140 physicians per hundred thousand citizens for only $50 billion per year, President Johnson declared a physician shortage and called for an immediate 50,000 additional physicians.

Understanding human nature and supplier induced need, Malcom Todd of the AMA warned, Mr. President, the more doctors you have, the more services, the more x-rays, the more surgeries are done. Not dissuaded, the administration passed legislation that doubled the graduation rates by the mid 70's.

Between 1965 and the present, the number of physicians, M.D.'s and D.O.'s, grew at five times the rate of the population to 265 per 100,000. Administrative personnel grew at 400 percent the rate of physicians, and health care costs rose to a trillion dollars per year, leaving 40 million Americans without health care insurance as a function of cost.

Although each physician had half the number of patients they had in 1965, their incomes did not fall. I mean, contrary to the laws of supply and demand, their average net incomes grew a steady 5.5 percent annually through 1964.

In 1973 Petersdorf warned of the developing oversupply, particularly of specialists. In 1980 the Graduate Medical Educational National Advisory Committee predicted an oversupply of 137,000

by the year 2000 and called for a 17 percent cutback. There was no cutback.

In 1983 Petersdorf, then dean of UC San Diego School of Medicine, wrote, "There is no longer any doubt. Those who question the data in 1978 can hardly doubt it now except perhaps for the boards, colleges and specialty medical societies, all of which are charter members of an academic right-to-life movement."

However, James Sammons asserted that the AMA had never acknowledged that there was a physician glut. This signaled the intransigence of the academic right-to-life group that persists to this day.

The oversupply robs physicians of their independence, detrimental to physician and patient alike. A physician glut is to the everlasting advantage of both the health care industry and of medical academia. Medicare largely unmanaged fee-for-service still is being plundered. Tests and treatments increased 300 percent in seven years. Losses from its hospital insurance trust fund total $4.2 billion for the first half of fiscal 1996, leading to speculation that the fund could run out of money by 2001.

Calls for cutbacks and downsizing of the physician corps are on the rise again. Such was a major plank of the Clinton health care reform

package of 1994, which was beaten down.

In 1995 the Pugh commission recommended that 20 percent of U.S. medical schools should be shut down by 2005. Why, they ask, did New York need 14 medical schools.

Nothing changes in medical academia. They speak only of a looming glut. Let the marketplace make the corrections, they say, knowing full well that medical schools and teaching hospitals are paid for with your tax dollars and mine and are not rightly of the marketplace. That 40 million Americans are without health care and insurance is a direct result of physician oversupply and cost overruns appears not to concern them.

The establishment of an appropriate physician supply appropriately distributed must be the primary plank of health care reform in America. Despite imperfections to be addressed on a case-to-case basis, managed care controls costs, is affordable and provides basic, humane care for many Americans deprived of it by a failed, immoral free market system. Encumber it now with complex, costly regulations, and you will only add to the still-growing millions of American men, women and children without access to health care.

I thank you.

DR. ENTHOVEN: Thank you, Doctor.

Questions?

All right. I take it that if one of the consequences of managed care in California was to force a cutback in residency programs that that would not be all bad, from what you're saying.

DR. BAUGHMAN: That would not be bad. I think that in fact residency programs plus graduate medical education has done nothing but grow in the past five years, and --

DR. ENTHOVEN: Despite the surplus?

DR. BAUGHMAN: In spite of the surplus acknowledged by everyone but the AMA and AAMC. And so, yes, there should be cutbacks in absolute numbers of doctors, and there should be cutbacks in most specialties as well.

DR. ENTHOVEN: Or perhaps maybe the finding we need to reach, based on what you said, is so far none of this seems to have had any effect on education training programs.

DR. BAUGHMAN: I mean, they are -- they are suffering the economic consequences of what the physician and specialty glut has wrought. And therefore they are now pleading for all kinds of help from the government to bail them out because -- because that -- I think that salaries in medical academia really did not go down until, I think, 1996 for the very first time, which is quite unlike the experience in the private practice sector.

DR. ENTHOVEN: Thank you very much,

Doctor.

We'll go to our last speaker, Joy Lynn, who is going to speak about managed care.

Thank you very much, Ms. Lynn, for coming.

MS. LYNN: I wasn't prepared. I didn't know about this 'til the last minute.

I recently have found that I have to use a wheelchair. I chose a chiropractor from my health care provider list. I started going to sessions, which were prior approved by the health care -- managed care group, which is American Chiropractic, if you want to know the name.

Then there was something went on between the chiropractor and the insurance company. I don't know. They wanted to drop her, one thing and another. Now I'm finding that they are not approving -- we requested nine sessions. They're approving three. Today I paid out of pocket for my chiropractor visit. That was just before I came here.

I very much identified with what this lady over here was talking about. I don't have the same particular diagnosis, you know. Mine has to do with my feet and legs and hips. But the same things are happening with me as with her. So I really identified with that.

I wrote down a few notes here. The

visits got less and less and less, less approval. The contract is that they will approve up to 30 visits a year. By the end of '96, they reduced them so that there were nine left that they didn't have to allow. '97 they're reducing them even more. So this is not a health plan really that is paying. The insurance companies get rich on this. Okay? They're making the money.

I'm also puzzled about how managed care is really saving any money. We've got -- first of all, we've got a referral doctor paying for a primary care physician. Then we go to the physician that's going to treat us. Then it goes and is reviewed by a physician at the insurance company, plus dozens and dozens - and I'm telling you dozens because I talk to them all - of administrative personnel.

Then if you disagree, there is a process of -- what do you call it?

MS. SKUBIK: Grievance?

MS. LYNN: Grievance and something else too, appeal. And I have it with me, I think. I've got some papers with me that I happen to have with me. And it goes on for 30 days, 60 days, 90 days, 120 days. And what's supposed to happen in the meantime?

Now, I started to improve. Last November I started to improve. And that's when they cut visits off. Now, my chiropractor was in a

meeting yesterday of American Chiropractic, and the doctor said, oh -- and he was discussing my case specifically. And the doctor said, oh, she's a chronic care, what's the point of giving her any care, she's chronic, the care isn't helping anyway, which is not true, by the way.

When I was cut off in November, I was so upset and depressed -- I mean, getting in a wheelchair is a really upsetting and depressing thing. I mean, this is devastating to somebody who is a very active person. I own my own business. I have to get to work or I'm going to go broke. I employ people. They would all lose their jobs. They are a contributing member. They are contributing members of society. We're all paying our taxes. And all that's going to go down the drain if I can't go to work. I have never accepted any public help at all ever.

I'd also like to comment on -- well, yeah, I want to say one more thing about the insurance companies. I did a few numbers. I don't have them here. I did them last year. And I was in such a rush, if I had known, if this had been more publicized, I would have come better prepared.

But with the few numbers I did, I kind of figure out that for the money that goes into building buildings on Wilshire Boulevard for insurance companies we could have a heck of a lot of

health care for an awful lot of poor kids, as well as adults and contributing members of society.

Now, what does that cost us? If they put me in bed and they pay me -- I don't know what they pay welfare or something, disability, whatever the government's going to pay me to stay in bed, and my staff of -- I have I think eight people in my office and 200 associates from other business that I subcontract with. And if all of them lose my business, who's gaining? Not our society. Not our government.

This is costing money. That's the bottom line. This is costing money.

I also want to comment on something that's really bothering me. And I don't know if this is the right place to do it. If it isn't, please stop me. But I am just really afraid of the lack of steril procedures used in this country. It's barbaric, as I see it. The doctors are not washing their hands. The dentists are not washing their hands. They're putting on non-steril gloves.

If I get them to wash their hands, they may pick up the box -- and I get them to. You know, no one's going to touch me without their washing their hands in front of me. But what do I do without my kids, my daughter, my staff. I'm starting to watch out --

DR. ENTHOVEN: We will have to stop. I

do feel that is outside the scope.

MS. LYNN: No, I appreciate that it's outside because I want to go on with just things that are inside the scope, and I don't want to take up too much more of your time.

I come from a different country. All industrial countries have some sort of health care system. People in this country seem to believe that this is the best health care system in the world, and I cannot believe people are buying it. I really can't believe people are buying it. This is the most barbaric thing I've ever seen in my life. People are dying in the streets.

One of my employee's child has asthma. She can't take him to the doctor because she hasn't been with me long enough to have health care, and she can't take the child to the doctor and the hospital, and the kid has asthma. I've seen kids die of asthma. I can't believe this is going on here. This is just a simple instance.

I'd like to suggest that we look at taking the insurance companies out of health care. Whatever you want to make of that you can make of that. Because there are systems. There are people who can create systems. It's a matter -- it's a simple matter of money. And if the insurance company didn't have such a large lobby, I don't think they'd be making so much money off the misery of the human

beings in this country.

So I'd like to see something done about that. That may also be without the scope. I'm not sure what the scope is, but that's what I'd like to --

DR. ENTHOVEN: Our assignment is basically to study the workings and impact of managed care and how that can be improved.

MS. LYNN: How that can be improved?

DR. ENTHOVEN: Yeah. We're getting close to our ending so --

MS. LYNN: I just want to say how it can be improved. It's only two words, eliminate it. You can get another system. Put another system in place. Put the insurance companies out of health care.

DR. ENTHOVEN: Okay.

MS. LYNN: This is not a place for profit.

DR. ENTHOVEN: All right. Thank you very much.

MS. LYNN: Thank you.

MR. LEE: Could I ask -- thanks for coming. How did you hear about this?

MS. LYNN: My friend told me that she heard something on KPBS about it. I was at home at 6:00, and I was told she heard something on KPBS about a meeting down here, and I said let's go.

DR. ROMERO: She heard about it today?

MS. LYNN: Today.

DR. ENTHOVEN: The task force meeting is now closed. I want to thank you very much for coming. The next task force will have another public meeting in Fresno on June 20. For members of the public that would like to attend that, please see the task force secretary to be placed on a mailing list. Thank you very much.

(The proceedings adjourned at 7:30 P.M.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN DIEGO)

I, Susan M. Kline, CSR 4617, a Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing proceedings were taken down by me in shorthand at the time and place named therein and were thereafter reduced to typewriting under my supervision and that this transcript is a true record and contains a full, true and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

EXECUTED this 18th day of June, 1997.

Susan M. Kline, CSR 4617